DEPARTMENT OF HEALTH & HUMAN SERVICES
Health Care Financing Administration

Center for Medicaid and State Operations
Family and Children's Health Program's Group
Division of Integrated Health Systems
7500 Security Boulevard
Baltimore, MD 21244-1850

SEP 11 1998

Mr. Greg Vadner
Director
Department of Social Services
Division of Medical Services
P.O. Box 6500
Jefferson City, Missouri 65102

Dear Mr. Vadner:

The Health Care Financing Administration (HCFA) has reviewed your August 20 response to our August 19 letter requesting further information on the proposed amendments to your approved Tide XXI program and your Section 1115 Medicaid demonstration entitled, Managed Care Plus (MC+). That request came about as a result of legislation which was passed by the Missouri State Legislature and which is to be effective August *26,* 1998. We are sending you our comments on your proposed amendment to your Tide XXI program under separate cover.

You are requesting a Section 1115 demonstration waiver to allow you to require a $5 *co-*payment at the time of professional service for children with a family income between 185 percent of the Federal Poverty Level (FPL) and 225 percent of the FPL; and to require a $10 co-payment at the time of the professional service, a *$5* co-payment per prescription, and *a* monthly premium for those children with a family income between *226* percent to 300 percent of the FPL. Co-payments would not be required for well-baby *or* well-child visits and immunizations, and total payments would be capped at five percent of the family's gross income. Non-payment of the premiums within 20 days of the premium due date would result in a six-month disenrollment from the MC + program.

Because section 1115 waivers should be "experimental, pilot, or demonstration" project(s) we *are* required to ensure that the proposed demonstration includes information on how the project will he evaluated. Therefore, in our August *19* letter to you, we sent you the following questions (i italics) and your answers and our comments on them are as follows:

1. *The Section 1115(a)(1) waivers requested and the Section 1115(a)(2) costs not otherwise matchable.*

Your answer was: "We clearly believe all associated cost are matchable. The only effect this change will have is to reduce associated costs."

We again ask that you *specify* the section 1115(a)(1) and 1115(a)(2) waivers requested.

2. *Descriptions of the populations affected and the rationale for applying the proposed cost-sharing.*

Your answer was: "Descriptions of the affected populations are clearly outlined in our June 26,1998 request. (Attachment 1)"

Please respond to our request for the rationale for applying the proposed cost-sharing.

3. *The hypotheses to be tested under the demonstration.*

4. *The research design, including data to be included, analysis plan, and who will conduct the evaluation. The analysis plan must cover the entire five-year demonstration period.*

Your answer covered questions #3 and #4: "The research design will be completed by the Department of Social Services Research and Evaluation Unit and an independent evaluator selected by a competitive bid process. The analysis will cover the five-year demonstration period. This evaluation will be part of our larger 1115 evaluation referenced in our original 1115 *waiver* submission (Attachment 3). In addition, we will complete all evaluations described in our state law under Sections 208.185.10 through 208.185.13 (Attachment 4). The results of these evaluations will be provided to the Health Care Financing Administration. We believe these evaluation efforts more than meet any 1115 requirements."

We are concerned that you did not respond to our request for the hypotheses to be tested under the demonstration, the research design, the data and the analysis plan.. The evaluations required under State law which you cite at s 208.185.10 through 208.185.13 do nor address cost sharing at all but instead address wraparound services for seriously emotionally disturbed children and children affected by substance abuse, a general annual report on *the* effect of the program, and a report on any negative effects the program has on privately insured children. Nor did you specify how the Section 1115 evaluation would be modified to include this additional research area We require a complete, substantive, and satisfactory response in order to approve your Section 1115 waiver request.

In addition to requiring substantive answers to our previous questions, please tell us how you will ensure the beneficiaries do nor exceed 5 percent of the family's gross income in their cost-sharing expenditures-

This proposal would require a waiver of Medicaid requirements through the authority of Section 1115. Thus, we will be reviewing this proposal consistent with our Section 1115 demonstration review process. We will work closely with you to ensure the review process moves as quickly as possible. Please be aware, however, that the proposed cos-sharing provisions cannot be implemented until all necessary Section 1115 Medicaid waivers are approved.

If you have questions or concerns regarding the matters raised in this letter, your staff may contact either Ms. Goetschius at (410) 786-0707 or Nan Foster-Reilly of the HCFA Region VII Division of Medicaid and State Operations, at (816) 426-3406. They will provide or arrange for any technical assistance that you may require in preparing your response. Your cooperation is greatly appreciated.

Sincerely.

/S/

Sidney Trieger
Director

cc: KCRO

SPECIAL BULLETIN
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MC + Illness

[redacted]

Missouri MEDICAID [redacted] Bulletin

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CHILDREN'S HEALTH INSURANCE PROGRAM

Title XXI, of the Social Security Act, established a new Children's Health Insurance Program (CHIP), to assist state efforts to provide health care coverage to uninsured, low-income children. In Missouri, this program is known as MC+ regardless of whether services are provided through a health plan or on a fee-for-service basis.

In Missouri, health care coverage has been expanded to provide coverage for uninsured children under the age of 19 from families with income up to 300% of the federal poverty level. To be considered uninsured, a child must have been without health insurance six (6) months prior to application. Some children can receive services without a co-pay. A co-pay for services is required for some children, and some will be required to pay a co-pay and family premium for coverage.

For those children who are approved for coverage without a premium, eligibility will begin on the date the application is received. Services furnished by Medicaid enrolled providers may be billed on a fee-for-service basis from the date of application. For those children who enroll in a health plan, fee-for-service may only be billed until the health plan coverage begins. For children who are approved for coverage with a premium, eligibility will begin 30 days after the application is received if the premium has been paid. The family premium must be paid prior to service delivery for those children subject to a premium.

The MC+ eligibles will enroll in a MC+ health plan in areas where MC+ health plans are the source of benefits, except the Northwestern MC+ region. Children in the Northwestern MC+ region, and children in all other counties not included in a MC+ region, will receive benefits on a fee-for-service basis.

The children eligible for health coverage under Title XXI will receive all current Medicaid services except Non-emergency Medical Transportation (NEMT). All current Medicaid limits and prior authorization requirements of all programs and services apply when providing services.

IDENTIFICATION OF NEW ELIGIBLES

ME codes "71" through "75" have been established to identify the new MC+ eligibles. The ME code is also used to identify those children who must pay a co-pay for services. Providers may call the Audio Response Unit (ARU) at (800) 392-0398 or use the Point of Service (POS) terminal to verify eligibility or health plan status.

ME codes "71", "72", and "73" identify those new MC+ eligible children who *do not* have to pay a co-pay.

Children with ME code "74" must pay a $5.00 co-pay for certain professional service visits.

Children with ME code "75" must pay a $10.00 co-pay for certain professional service visits and a $5.00 co-pay for each prescription.

Children with ME codes 71, 72, 73, 74 and 75 are *not* subject to day specific eligibility, and once approved individuals are eligible for services through the last day of the month that coverage ends.

A new MC+ health plan enrollee group (Group 5) has been added to incorporate eligibles who are in a MC+ health plan area. MC+ health plan eligible children in Group 5 receive behavioral health care through the health plan.

CO-PAY REQUIREMENTS

The co-pay requirement for children with ME codes "74" and "75" applies to both fee-for-service individuals and health plan enrollees. The provider of service is responsible for collecting the co-pay from the patient. Unlike the current Medicaid policy which states, *providers may not deny services based on the recipient's inability to pay*, providers may deny services for children in ME code "74" and "75" if they do not pay co-pay.

The co-pay requirement for MC+ eligible children with ME codes "74" or "75" is not to be confused with or added to any other cost sharing or pharmacy dispensing fees applicable to the current Medicaid fee-for-service program requirements, or the pharmacy dispensing fee requirement of MC+ health plans. The only co-pay that applies to identified services for children with an ME code "74" is the $5.00 co-pay for identified services. Children with and ME code "75" must pay a $10.00 co-pay for identified services, and a $5.00 co-pay per prescription. The co-pay applies whether the child receives health care on a fee-for-service basis or is enrolled in a health plan.

The co-pay amount will be deducted from the Medicaid Maximum Allowable amount for fee-for-service claims reimbursed by the Division of Medical Services.

EXCEPTIONS TO CO-PAY REQUIREMENTS

Services for well child care are exempt from the co-pay requirement. To be identified as a well child care service the provider must include an appropriate well child diagnosis of V202, V680, V700 or V703 on the fee-for-service claim, or be reported to the health plan. If the exempt diagnosis code does not appear on the fee-for-service claim, the required co-pay amount will be deducted from the Maximum Allowable Amount before reimbursement.

Services for immunizations are exempt from the co-pay requirement. Providers may not bill an office visit or charge a co-pay for the exclusive reason of administering a vaccine. If a vaccine is administered as an incidental care service during an office visit that is not exempt from the co-pay requirement, a co-pay will apply.

PROVIDERS WHO MAY NOT CHARGE A CO-PAY

The following providers may not charge co-pay for services.

Provider Type	Provider Name
15,16,17,18	Case Management
20, 24, 42	SAFE/CARE (for SAFE/CARE exams only)
26	Personal Care
28	Elderly Waiver
29	Adult Day Health
58	AIDS Waiver
62	DME
70	Lab
71	X-Ray
75	QMB Only
80	Ambulance
82	Hospice
85	MRDD Waiver
91	CRNA (anesthesia)
94	Private Duty Nursing

PROCEDURES REQUIRING A CO-PAY

The following charts show the provider types and procedure codes for each program for which the co-pay amount will be deducted from the Medicaid Maximum Allowable Amount.

Ambulatory Surgical Center			
Provider Type	Type of Service	Procedure Code	Description
50 (B5)	9	The co-pay applies to the major surgical procedure code.	

Physician - Nurse Midwife - Nurse Practitioner - Clinic - Teaching Institution - Federally Qualified Health Center (FQHC) - Health Department - Planned Parenthood - Hospital Based Rural Health Clinic (RHC) - Dental - Podiatrist - Optician - Optometrist - Optometry Clinic - Community Mental Health Center - Independent Rural Health Clinic

Provider Type	Type of Service	Procedure Code	Description
20, 24, 25, 30, 31, 40, 42, 50, 51, 52, 53, 54, 55, 56, 59	1,3,6,7,9,B	99201	New Patient-Office or Outpatient Visit
	1,3,6,7,9,B	99202	New Patient-Office or Outpatient Visit
	1,3,6,7,9,B	99203	New Patient-Office or Outpatient Visit
	1,3,6,9,B	99204	New Patient-Office or Outpatient Visit
	1,3,6,9,B	99205	New Patient-Office or Outpatient Visit
	1,3,6,7,9,B	99211	Established Patient-Office or Outpatient Visit
	1,3,6,7,9,B	99212	Established Patient-Office or Outpatient Visit
	1,3,6,7,9,B	99213	Established Patient-Office or Outpatient Visit
	1,3,6,9, B	99214	Established Patient-Office or Outpatient Visit
	1,3,6,9, B	99215	Established Patient-Office or Outpatient Visit
	1,B	92002	Medical Exam & Eval - New Patient
	1,B	92004	Comprehensive - New Patient Visit
	1,B	92012	Medical Exam & Eval - Established Patient
	1,B	92014	Comprehensive - Established Patient Visit
	1,B	92015	Refraction
	B	Y4000	Complete Eye Exam
	B	Y4001	Limited Eye Exam
	1,B	92081	Visual Field Exam
	1,B	92082	Intermediate Visual Field Exam
	1,B	92083	Extended Visual Field Exam
	1,B	92283	Color Vision Exam
59	1	Z7000	Encounter Code for Independent Rural Health Clinic

Certain providers can bill codes for children with a YG modifier.

TOS 6 uses a W2 modifier to distinguish an outpetient visit from an office visit.

An FQHC may need to collect more than one co-pay per day (based on performing provider)

No co-pay on treatment services, co-pay is charged only when the above office visit code are billed.

Co-pay is exempt for an office visit / well child check with a diagnosis code of V202, V680, V700 or V703.

Only one optical evaluation or office visit code can be billed on a single date of service.

Speech Therapist - Occupational Therapist - Physical Therapist - Rehabilitation Center

Provider Type	Type of Service	Procedure Code	Description
46, 47, 48 57	M, K	92506YG	Speech Therapy Evaluation
	M, K	97703YG	Occupational Therapy Evaluation
	M, K	97750YG	Physical Therapy Evaluation
No co-pay applies to IEP/IFSP services billed with a WQ modifier.			

Comprehensive Day Rehabilitation Center

Provider Type	Type of Service	Procedure Code	Description
76	9	W1363	Half-Day Eval/assessment
	9	W1364	Full-Day Eval/assessment

Psychiatrist - Psychologist - Licensed Clinical Social Worker - Licensed Professional Counselor - Community Mental Health Center

Provider Type	Type of Service	Procedure Code	Description
20, 24, 49,56	1, M	90801	Assessment (Diagnostic Interview) {allowed units = 6)
	1, M	96100	Testing {allowed units = 8)
Co-pay is applied once regardless of how often the procedure code is billed to get the total allowed units. Community Mental Health providers employ psychiatrists who can bill testing and assessment.			

Home Health

Provider Type	Type of Service	Procedure Code	Description
58	Z	W0026	HCY Skilled Nurse Evaluation
	Z	W0027	HCY Occupational Therapy Evaluation
	Z	W0028	HCY Physical Therapy Evaluation
	Z	W0029	HCY Speech Therapy Evaluation
No co-pay applies to IEP/IFSP services billed with a WQ modifier.			